DEPARTMENT OF HEALTH AND HUMAN SERVICES

To: 18592462307

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PRINTED: 02/09/2011

**FORM APPROVED** 

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. (					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185254	e. wii	NG _		1	C <b>5/2011</b>	
	PROVIDER OR SUPPLIER VAY NURSING & REM	ABILITATION FACILITY	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 06 WYOMING ROAD #38 DWINGSVILLE, KY 40360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 000 F 221 SS=G	A Recertification State were initiated on 01 01/25/11. Deficient scope and severity Survey was conduct highest scope and #KY00015475 was practice. ARO #KY unsubstantiated wit #KY00015803 was deficient practice id was cited at F 465. 483.13(a) RIGHT T PHYSICAL RESTR	Invey and Abbreviated Survey /18/11 and concluded on cles were cited with the highest being a "G". A Life Safety sted on 01/18/11 with the severity being "F". ARO substantiated with no deficient /00015649 was in no deficient practice. ARO substantiated with the G-level entified. A repeat deficiency  O BE FREE FROM AINTS  e right to be free from any mposed for purposes of hience, and not required to	The same	O00	Rehabilitation does not belied does the facility admit that a deficiencies exist.  Ridgeway Nursing and Rehabilitation reserves all ricontest the survey findings to informat dispute resolution, appeal proceedings or any admittative or legal proceedings or any admittative an admission regal any facts or circumstances surrounding any alleged defit to which it responds; nor is to establish any standard car	ights to through legal eedings not arding iciencies it meant re,		
	This REQUIREMENT by: Based on observation review it was determidentify changes in use (side ralls) for cresidents (Resident attempt to eliminate for Resident #13. (from the bed with it facility failed to identifisk for climbing over Rail Assessment".	on, interview and record mined the facility failed to risk factors related to restraint one (1) of twenty (20) sampled #13). The facility failed to or reduce physical restraints on 06/17/10, Resident #13 fell he side rails raised. The attify that Resident #13 was at or the side rails per the "Side Resident #13 sustained a bed with side rails raised on #13 was hospitalized for			contract, obligation or positic Ridgeway Nursing and Rehabilitation reserves all risease all possible contentions defenses in any type of civil criminal claim, action or proposition of this placement of any type of civil or criminal claim, action or proposition of this placement of any type of civil or criminal claim, action or proposition of this placement of any potentially appear review, quality assurance critical examination privileger	ghts to s and or occeding. an of ered as a r occeding. an of ered as a plicable ce or self		
ABORATOR	PORECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		Exercise Direct	<u></u>	(X6) CATE!	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the lindings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER,			COMPLETED				
_		185254	1	<u>-                                    </u>		01/26	3/2011
	ROVIDER OR SUPPLIER  AY NURSING & REHA	ABILITATION FACILITY		40	EET AODRESS, CITY, STATE, ZIP CODE DE WYOMING ROAD #38 WINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	IEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 221	revealed side rail a completed upon ac Minimum Data Set any significant charcould be considere assessed as a rest treated accordingly were completed with assessments.  Review of the clinical diagnoses which in Depression. Furth the facility assesses short and long-term	e:  Rail Assessment" policy ssessments should be Imission, quarterly with the (MDS) assessment, and with nge. Additionally, full side rails d a restraint, and if they were raint, the side rails should be to the side rail assessments	F	221	Ridgeway Nursing and Rehabilitation does not wais reserves the right to assert in administrative, civil, or crim claim, action, or proceeding Ridgeway Nursing and Rehabilitation offers its responded by allegations of compand plan of correction as parongoing ciliort to provide quare to residents.  Ridgeway Nursing and Rehabilitation strives to prohighest quality care while as the rights and safety of all residence.	n any ninal nonses, pliance rt of its rality vide the ssuring	
	o1/09/02, revealed reassessing the us had an incident (fause of restraints. Feel were to be re-evaluatermine their copolicy stated the fato eliminate the us Review of the clini#13 was admitted diagnoses which in Depression. Review Data Set assessment the facility assessment.	eview of the "Restraint-Physical" policy, dated 1/09/02, revealed no information related to passessing the use of a restraint after a resident ad an incident (fall) which may be related to the se of restraints. Per the facility's policy, restraints ere to be re-evaluated at least quarterly to atermine their continued need. Additionally, the olicy stated the facility should make every effort a eliminate the use of the restraint.  Ineview of the clinical record revealed Resident 13 was admitted to the facility on 02/16/04 with diagnoses which included Dementia and lepression. Review of the quarterly Minimum that set assessments dated 05/08/10 revealed the facility assessed Resident #13's side rails to be restraints. Review of the "Side Rail"			F221 It is and was on the c survey the policy of Ridges Nursing and Rehabilitation the residents are free from physical restraints improve purpose of discipline or cor 1. Resident #13's side rail assessment has been review updated. At this time there changes in her assessment it time of survey. This assess reviewed on 02/17/11.	vay to ensure any d for nvenience.  ved and were no from the	02/18/11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLEYED C	
•		185254	B. WIN	IG		1	5/2011
	PROVIDER OR SUPPLIE	HABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD #38 OWINGSVILLE, KY 40360				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X6) COMPLETION DATE
F 221	assessed that the resident would cl with RN #3/MDS conducting a revi interview staff, re any incident report completed.  Review of Physic Record" revealed initially ordered or revealed the Phymedical condition did the Physician's of the Physician's of meant the four side relis were to 01/21/11 at 6:45 the Physician's of meant the four side relis was usually had two (Review of the "CO5/12/10, revealed relis was for injury. Review of the "Naccident/Incident revealed Reside floor beside the resident and four report, the resident the two (2) lincident report in the report i	ted 04/30/10, revealed the facility ere was no possibility the lmb over the side rails. Interview Coordinator revealed when ew of the side rails she would view clinical records, and look at its that may have been lian's Orders and the "Treatment I Resident #13's side rails were in 03/16/10. Further review sician's order did not have a for the use of the side rails, nor is orders identify which type of be used. In interview, on PM, RN #3/MOS nurse stated rails would be up. She as due to the facility's beds 2) full side rails.  comprehensive Care Plan' dated at Resident #13's side rails were straint. The facility's goal for the the care plan revealed it did not addor the number of side rails that	F	221	2. The Director of Nursing all residents with side rail or accuracy of the assessments possible reduction. All restreviewed weekly in the faci quality of care meeting; this done on 02/17/11. No other problems were identified an residents were in the least redevice.  3. As part of the weekly que care meeting the facility will restraint assessments to ensileast restrictive measure is lused. In addition, if a reside experiences a fall or accided Director of Nursing will revappropriate assessment for changes within 72 hours of incident. Inservice education provided to all licensed staff LPN, and CNAs) by the Administrator on 02/04/11 orders and individualized carelated to restraint usage.	rders for it, and raints are lity's so was read all estrictive ality of ll review ure the being ent in the view the any of lRN, related to	

PRINTED: 02/09/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT(PLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A BUILDING C B, WING 185254 01/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (XS) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 221 Continued From page 3 F 221 4. As part of the facility's ongoing continuation of frequent visual checks, encourage quality assurance program the resident not to stand/transfer without assistance, Director of Nursing will audit 10% and the addition of a pressure pad alarm to the of all restraint assessments monthly bed. Review of the "Comprehensive Care Plan" for six months to ensure accuracy. revised on 06/17/10, revealed the care plan included the interventions from the "Resident Weekly the facility will continue to Accident/Incident Report". monitor restraint usage and assessments during the quality of Interview, on 01/24/11 at 7:19 PM, with care meeting. Registered Nurse (RN) #2 revealed she was on duty 06/17/10 when Resident #13 was found on the floor. The RN stated the resident had to have "squirmed" through the side rails in order to get out of bed. Interview, on 01/24/11 at 4:51 PM, with State Registered Nurse Aide (SRNA) #13 revealed he was on duty 06/17/10 when Resident #13 was found on the floor. Per the SRNA the side ralls were up. The SRNA stated Resident #13 would stide to the foot of the bed and try to get out. He stated the nurses were aware of the resident's habit of sliding to the foot of the bed. In interview, on 01/24/11 at 5;49 PM, SRNA #7 was on duty when Resident #13 fell on 06/17/10. SRNA #7 stated the side rails were up when she entered the room to assist with the resident. The SRNA verified the resident would slide to the foot of the bed and attempt to get up. She stated the nurses were aware the residents attempts to get out of bad.

climb out of the bed".

Interview, on 01/24/11 at 5:28 PM, with SRNA #5 revealed Resident #13 tried to climb out of the bed prior to the fall on 06/17/10 and "still tries to

Interview, on 01/25/11 at 3:50 PM, with RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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RIDGEWAY NURSING & REHABILITATION FACILITY  (KA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH GERECITION SEGULATION FOR LISE OPENITARIES (EACH GERECITION SEGULATION FOR LISE OPENITARIES OF THE SEGULATION FOR SEGU			185254	B WING			_
F 221  Continued From page 4  #3/MDS Coordinator revealed after review of the incident report and the Nurse's Note, she did not see anything about the side rails; therefore she did not complete a "Side Rail Assessment" for the O8/17/10 fall. RN #3 steted she had completed the O8/12/10 fall follow-up assessment on Resident #13 after the fall on O8/12/10 and could see no reason to add any other interventions than those she had suggested; even though the documentation on the incident report detailed the resident was getting in and out of bed with side rails up.  Interview, on O1/25/11 at 2:53 PM, with Licensed Practical Nurse (LPN) #1, who also completed "Side Rail Assessment"; revealed based on her review of the incident report, deted 06/17/10, and the Nurse's Notes for the O8/17/10 fall, she would need to complete a more comprehensive review of the side rails to determine the need for their continued use.  Further record review revealed no documented evidence that the facility re-assessed to determine whether Resident #13's continued use of the off-17/10 and the Nurse's Note of the O8/17/10 and sound the side rails was sale.  Interview, on 01/25/11 at 3:55 PM, with the Vice President of Clinical Operations revealed based on the incident report and the Nurse's Note for the 06/17/10 (1), she would assume the resident had climbed out of the bad but would need additional information.  Review of the Minimum Data Set assessments dated 07/30/10 revealed the facility assessed Resident #13's side rails as restraints.  Review of the "Side Rail Assessment" dated	-	-		408	WYOMING ROAD #35	CODÉ	
#3/MDS Coordinator revealed after review of the incident report and the Nurse's Note, she did not see anything about the side rails; therefore she did not complete a "Side Rail Assessment" for the 08/17/10 fail. RN #3 steted she had completed the 06/12/10 fail follow-up assessment on Resident #13 after the fail on 06/12/10 and could see no reason to add any other interventions than those she had suggested; even though the documentation on the incident report detailed the resident was getting in and out of bed with side rails up.  Interview, on 01/25/11 at 2:53 PM, with Licensed Practical Nurse (LPN) #1, who also completed "Side Rail Assessments", revealed based on her review of the incident report, dated 06/17/10, and the Nurse's Notes for the 06/17/10 fail, she would need to camplete a more comprehensive review of the side rails to determine the need for their continued use.  Further record review revealed no documented evidence that the facility re-assessed to determine whether Resident #13's continued use of the side rails was safe.  Interview, on 01/25/11 at 3:55 PM, with the Vice President of Clinical Operations revealed based on the incident report and the Nurse's Note for the 06/17/10 fail, she would assume the resident had olimbed out of the bed but would need additional information.  Review of the Minimum Data Set assessments dated 07/30/10 revealed the facility assessed Resident #13's side rails as restraints.  Review of the "Side Rail Assessment" dated	PRÉFIX	(EACH DEFICIENT	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION
President of Clinical Operations revealed based on the incident report and the Nurse's Note for the 06/17/10 fall, she would assume the resident had climbed out of the bed but would need additional information.  Review of the Minimum Data Set assessments dated 07/30/10 revealed the facility assessed Resident #13's side rails as restraints.  Review of the "Side Rail Assessment" dated	F 221	#3/MDS Coordina incident report an see anything about did not complete 06/17/10 fall. RN the 06/12/10 fall I Resident #13 afte see no reason to those she had surdocumentation or resident was getti rails up.  Interview, on 01/2 Practical Nurse (I "Side Rail Assess review of the incident Nurse's Noteineed to complete of the side rails to continued use. Further record reevidence that the determine whether	attor revealed after review of the dithe Nurse's Note, she did not but the side rails; therefore she a "Side Rall Assessment" for the #3 steted she had completed ollow-up assessment on in the fall on 06/12/10 and could add any other interventions than ggested; even though the interventions than ggested; even though the ing in and out of bed with side.  25/11 at 2:53 PM, with Licensed in and out of bed with side.  25/11 at 2:53 PM, with Licensed in the incident report detailed the ing in and out of bed with side.  25/11 at 2:53 PM, with Licensed in and out of bed based on her dent report, dated 06/17/10, and is for the 06/17/10 fall, she would a more comprehensive review of determine the need for their view revealed no documented in acility re-assessed to er Resident #13's continued use	F 221			
		President of Clinion the incident rethe 06/17/10 fall, had climbed out additional inform Review of the MI dated 07/30/10 r. Resident #13's s.	ical Operations revealed based opert and the Nurse's Note for she would assume the resident of the bed but would need ation.  nimum Data Set assessments evealed the facility assessed ide rails as restraints.				
Event ID: 095811 Fedility ID: 100427 If continuation sheet Page 5 of 3		Review of the 'S	Ide Rali Assessment' dated				

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OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING C B. WING \_ 01/25/2011 185254 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 408 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 221 F 221 Continued From page 5 07/30/10 revealed the facility continued to assess that there was no possibility that Resident #13 would climb over the side rails. Record review revealed these assessments were completed by RN #3/MDS Coordinator. Interview with RN #3/MDS Coordinator revealed when conducting a review of side rails she would Interview staff, review clinical records and look at incident reports that may have been completed. However, lurther review of these assessments revealed no evidence RN #3/MDS Coordinator considered the 06/17/10 fall involving the side rails when completing the side rail assessment to determine the safety of this resident's continued use of side rails. Review of the "Nurse's Notes", dated 08/08/10 at 9:30 AM, revealed Resident #13 had been found lying on the floor and was assessed to have no injuries. Per the Note, the resident was found on the floor and the side ralls were still up. At 9:30 AM, an assessment of Resident #13 revealed no apparent injury. Additional Notes timed at 12:00 PM and 12:30 PM revealed no discomfort was noted. Per the 1:30 PM entry Resident #13 was noted to have pain in the right lower extremity upon transfer to bed and was sent to the hospital for further evaluation. Review of the \*Progress Note", dated 08/11/10, revealed the resident had undergone a Total Hip Arthroplasty (hip replacement) after a fracture to the right hip. Additionally, the Nurse's Notes detailed the incident report was faxed to the Physician. However, the facility was unable to provide documented evidence of the incident report, for this fall. Interview, on 01/24/11 at 4:41 PM, with RN #1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	ROVIDER OR SUPPLIER AY NURSING & REH	ABILITATION FACILITY		40	EET ADDRESS, CITY, STATE, ZIP CODE 16 WYOMING ROAD #38 WINGSVILLE, KY 40360		
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F 221	resident sustained she entered the resilying on the floor. would have had to rails or out the foot 08/08/10 fall was the sident #13 had finterview, on 01/25 Registered Nurse / Resident #13 was entered the room of the side rails were review of the Sign	on duly on 08/08/10, when the a fall. The RN stated when sident's room the resident was The RN stated the resident have climbed over the side of the bed. The RN stated the ne first time she was aware that fallen getting out of bed.  1/11 at 10:43 AM, with State Aide (SRNA) #6 revealed sitting on the floor when she on 08/08/10. The aide stated	F	221			
	facility assessed Frestraints.  Review of the "Resummary" (RAPS) facility assessed Frestraint and the urelated to a history. The RAPS did not usage as a restrainfactors associated Additionally, the Rexperienced a rec. However, the facilitisk factors related regarding the residual control of the "Side Review of the "Side Revi	sident #13's side rails as sident Assessment Protocol dated 08/26/10, revealed the lesident #13 to have a physical se of an atarming seatbelt of falls from the wheelchair. Identify the resident's side rail int and did not detail any risk with the use of the side rails. APS detailed the resident had ent fall with hip fracture. Ity did not identify/address the Ito the use of side rails dent's falls on 06/17/10 and					
		an assessment date of					

08/20/10 revealed the facility continued to assess the resident to have no possibility to climb over

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED		
		185254	9. WING		C 01/25/2011	
	ROVIDER OR SUPPLIER AY NURSING & REH	ABILITATION FACILITY	40	EET ADDRESS, CITY, STATE, ZIP CODE 6 WYOMING FIOAD #38 WINGSVILLE, KY 40360		
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F 221 SS≠E	the side rails. The evidence the facilitie eliminate the use of through 01/24/11.  Interviews, on 01/26/19 PM, with SRit revealed they were would scoot to the get up. They state Resident #13 would interviews, on 0 PM and on 01/25/RN #3 and LPN # #13's attempt to go Observation of Refined With side rails 01/21/11 at 12:40 lying on the bed with side rails 01/21/11 at 3:42 Flying on the bed with side rail on the lef 01/24/11 at 3:42 Flying on the bed with side rail on the rig 01/24/11 at 5:15 Fon the bed with for Random observat AM until 3:20 PM, on the bed with to 483.13(c)(1)(ii)-(ii) RIVESTIGATE/RIALLEGATIONS/III	tre was no documented by attempted to reduce or of the side rails from 03/15/10  24/11 at 4:51 PM, 5:28 PM, and NAS #5, #6, #7 and #13  a aware that Resident #13  foot of the bed and attempt to ed the nurses were aware attempt to get out of bed.  24/11 at 4:41 PM and 7:18  11 at 2:45 PM RN #1, RN #2, 1 dented knowledge of Resident et out of bed unassisted.  25/24/11 at 4:41 PM and 7:18  26/24/11 at 4:41 PM and 7:18  27/24/11 at 4:41 PM and 7:18  28/24/11 at 4:41 PM and 7:18  29/24/11 at 4:41 PM and 7:18  20/24/11 at 4:41 PM and 7:18  20/24/11 at 4:41 PM and 7:18  20/24/11 at 4:41 PM and 7:18  21/24/11 at 4:41 PM and 4:41  22/24/11 at 4:41 PM and attempt to determine the selection of the selecti	F 225	F225 It is and was on the d survey the policy of Ridgev Nursing and Rehabilitation that all alleged violations in	vay to ensure	1
	been found guilty	of abusing, neglecting, or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185254	B WING	-	C 01/26/2011	
	PROVIDER OR SUPPLIES	HABILITATION FACILITY	4	REET ADDRESS, CITY, STATE, ZIP CODE 108 WYOMING ROAD #38 DWINGSVILLE, KY 40360	1 1124(20)	
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F 225	mistreating residented a finding entergistry concerning of residents or mind and report any known of law again indicate unfitness other facility staff or licensing author licensing injuries misappropriation immediately to the toother officials in through establish State survey and The facility must be violations are the prevent further poinvestigation is in the results of all to the administrative an with State law (Indicentification agent incident, and if the	ents by a court of law; or have ared into the State nurse aide ag abuse, neglect, mistreatment sappropriation of their property; lowledge it has of actions by a lest an employee, which would for service as a nurse aide or to the State nurse aide registry writtes.  Sensure that all alleged violations ment, neglect, or abuse, of unknown source and of resident property are reported a administrator of the facility and in accordance with State law and procedures (including to the certification agency).	F 225	including injuries of unknow source, and misappropriation reported immediately. The idescribed in the statement of deficiencies all involved resiliation who were confused. The desof abuse is "a willful intent" was no willful intent on the pany resident described in this statement of deficiencies.  1. Resident #13 is now bed for confused to time, place, and Resident #9's skin is intact a skin tear healed without complications.  Resident #10 continues to had diagnosis of dementia with behavioral disturbances, with further behavioral issues. Refurther behavioral issues. Refut the receives psychiatric care routinely with medication adjustments. No further incihave been noted.	on are noidents dents finition. There part of s and person, and the leve a leve	
	by: Based on Intervie determined the fa	ENT is not met as evidenced wand record review it was cility failed to ensure all alleged g mistreatment, neglect or		Resident #11 has a diagnosis mental retardation. He recei psychiatric care through Path and has had numerous medicadjustments. No further incihave been noted with resider	ves nways cation dents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT(FICATION NUMBER:	NUMBER: A BU		3	(X3) DATE SURVEY COMPLETED C	
		185254				01/25	5/2011
	ROVIDER OR SUPPLIER  AY NURSING & REH	ABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 405 WYOMING ROAD #35 OWINGSVILLE, KY 40350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOTO CROSS-REPERENCED TO THE APPROPRICE OF THE	ULO BE	(X5) COMPLETION DATE
F 225	25 Continued From page 9 abuse including injuries of unknown origin, were reported immediately to the appropriate State Agency as evidenced by the facility falling to report three (3) different allegations of abuse involving five (5) of nineteen (19) sampled residents (Resident #7, #9, #10, #11, and #13). The findings include:  Review of the facility's policy and procedures entitled "Abuse Reporting" revealed upon receiving reports of mistreatment, abuse, misappropriation of property, or neglect, the Administrator or Director of Nursing will immediately report the incident to the appropriate State Agencies. In the event the Administrator or the Director of Nursing is not available, the charge nurse will report the incident Immediately.				Resident #7 was not harmed not have any adverse effects to the incident in question. Tresident has a primary diagnoral Alzheimer's.  2. All staff (licensed and un were inserviced on 02/04/11 Ombudsman and Administrational abuse reporting protocol and need to report immediately, Resident Rights. During the council (approximately 18 rewere questioned related to pabuse by other residents.	related This osis of licensed) by the stor on the and on resident	
	revealed documer altercation involvir #9. Review of the 06/17/10, revealed and stuck it into R tear. Further reviewed the facilit to have severe co developed a care disruptive behavior history of recurrer threatening behavioratening behavioratening behaviors with Liceno 01/21/11 at 4:3 took flowers out of metal end on one	clinical record for Resident #13 Intation of a resident to resident ing Resident #13 and Resident ing Resident #13 and Resident ing Resident #13 and Resident ing Resident #13 took a sharp pin esident #9's leg causing a skin is worthe clinical record ity had assessed Resident #13 gnitive impairment. The facility plan for Resident #13 for interrelated to dementia with a int behaviors and intermittent itiors. The facility had assessed we modified independence with king.  ensed Practical Nurse (LPN) #2 IO PM, revealed Resident #13 If the flower pot and stuck the of the facility's reports revealed			3. The Administrator and D of Nursing will review all in reports (Monday through Frishift reports to ensure any alviolation of abuse, neglect, omisappropriation is reported immediately to all appropria agencies, and a thorough investigation is conducted arresidents are protected durin investigation. Per the facilit any allegations of abuse will reported immediately to the Administrator.	cident iday) and leged or ite ind ig the y policy	

(NS) COMPLETION

DATE

**FORM APPROVED** 

PRINTED: 02/09/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) OATE SURVEY (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING

COMPLETED AND PLAN OF CORRECTION 185254 01/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

### RIDGEWAY NURSING & REHABILITATION FACILITY

408 WYOMING ROAD #38 OWINGSVILLE, KY 40360

PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 225 F 225 Continued From page 10 a Resident Accident/Incident Report was

- completed on 06/17/11 with a follow-up report completed on 06/17/11. However, there was no documented evidence the incident had been reported to the appropriate State Agencies.
- 2. Review of the ofinical record for Resident #10 revealed two resident to resident altercations involving Resident #10. On 06/16/10 review of a Resident Accident/Incident Report revealed Resident #10 was shouting and punching another resident. The report stated the other resident obtained scratches on the arm. The resident who was injured was not identified. On 07/09/10 review of the Resident Accident/Incident Report revealed Resident #10 was observed to filt another resident in the chest. The resident who was hit was not Identified. The report Indicated this resident was not injured. There was no documented evidence these two incidents had been reported to the appropriate State Agencies.

Review of the clinical record revealed the facility had assessed Resident #10 to be moderately Impaired in daily decision making. The resident had several diagnoses which included Dementia with Behavioral Disturbances.

Interview with the Minimum Data Set (MDS) Coordinator on 01/21/11 at 6:30 PM revealed she could not remember the other residents involved in the 06/16/10 or 07/09/10 incident.

Interview with Registered Nurse (RN) #1 on 01/21/11 at 6:45 PM, revealed she was the nurse who had filled out the incident report on 07/09/10, but could not remember the other resident who was involved.

4. As part of the facility's ongoing quality assurance program the Administrator and Social Service Director will review any incident of resident to resident abuse to ensure it is reported to proper authorities. These incidents will be forwarded to the OA committee for review monthly. This will be ongoing.

If continuation sheet Page 11 of 30

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	С	
	•	185254	B. WING _		01/25/2011	
	ROVIDER OR SUPPLIER  AY NURSING & REH	ABILITATION FACILITY	4	EET ADDRESS, CITY, STATE, ZIP CODE 08 WYOMING ROAD #38 WINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDEN'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 225	3. Review of the of revealed a resident Review of the Nurs revealed Resident	ge 11 inical record for Resident #11 to resident altercation. e's Notes on 10/22/10 #11 was rubbing another k and was inappropriate with	F 225			
	at 10:15 AM reveal kissing Resident #7 and record review fone to one supervisione to one supervisione resident was taund sent for a psyc 10/25/10. The resident was the resident was the residual form of the residual form.	pirector of Nursing on 01/20/11 and Resident #11 was observed on 10/22/10. Per interview Resident #11 was placed on alon until the family arrived. aken home for the weekend, hological evaluation on dent returned to the facility on as no documented evidence en reported to the appropriate				
	#11 had several dia Retardation (MR). care plen for Residinappropriate/disruj	al record revealed Resident ignoses which included Mental The facility had developed a ent #11 for socially otive behavior which included al comments/behavior at times				
F 281 SS=D	Services on 01/21// believed there was the cognitive levels incidents did not ne Agencies. 483.20(k)(3)(I) SEF PROFESSIONAL S The services provice	Ice President of Clinical It at 9:50 PM, revealed she no intent for abuse related to of residents involved and the ed to be reported to the State IVICES PROVIDED MEET STANDARDS Ited or arranged by the facility onal standards of quality.	F 281	F281 It is and was on the da survey the policy of Ridgewa Nursing and Rehabilitation to services provided or arranged facility meet professional states of quality.	02/18/11 o ensure il by the	

		AND HUMAN SERVICES				FORM	: 02/09/2011 APPROVED : 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SO COMPLE	TED
	·	185254	8. W(	NG		i	C 5/2011
IAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGEW	ay nursing & Reh	ABILITATION FACILITY			406 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
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F 281	Continued From pa	ge 12	F	28			
	by: Based on interview determined the face physician's orders to sampled residents had a physician's 0 08/05/10. The fact 08/17/10.	and record review it was lifty failed to carry out or one (1) of nineteen (19) (Resident #7). Resident #7 rder to have a urinalysis on lifty failed to obtain the test until			1. The urinalysis on Resident refused. Resident refused. Resident remains in the facility and additional urinalysis since which were reviewed in act to physician's orders and cordered.	wever the #7 has had 08/17/10, ecordance obtained as	
	Review of the clinical record revealed, a physician's order was obtained for a urinalysis to be completed on Resident #7 on 08/05/10. However, there was no documented evidence that the urinalysis was completed until 08/17/10. Review of the Nurse's Notes dated 08/06/10, revealed an attempt to obtain a urinalysis had been unsuccessful related to the resident being agiteted. However, there was no documented evidence that other attempts to obtain the urinalysis were made.  affects monitored monitors.			2. All residents could potentially be affected. All ordered labs are monitored by the Director of Nursing on a daily basis to ensure there are none missed. This will be accomplished by reviewing the requisitions and lab calendar. This process will be ongoing.  3. Labs ordered are placed on the lab calendar by the nurse receiving the order, daily medical records			
	policy dated 11/02/ the admitting nurse order would docum calender. Step #3 person would check lab requisition for to #4 indicated that a be maintained in a until the results we physician.	ly's "Lab Monitoring System"  07, revealed Step # 2 stated or the nurse receiving the sent the order on the laboratory stated the medical record is the calender and complete a he labs to be obtained. Step copy of the requisition would notebook at the nurse's station re returned and reported to the  Director of Nursing (DON) on M, revealed she was not			completes lab requisition for lab day. A copy of the requisition of maintained in a notebook and nurse's station until lab response returned and reported to the physician. The copy will be removed from the notebook nurse after he/she reports to the physician. If a requiremains in the notebook the	or the next uisition is at the sults are e be k by the he results sition	
BM CMS-2	567(02-99) Previous Version	Obsciete Eveni ID: 095R11			Facility IO: 100427 If co	nlinuation sheet	Page 13 of 3

To: 18592462307

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

EXATEMENT OF DESICIPACIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 02/09/2011 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, _,	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		185254	B. WING _		h	C 5/2011
	ROVIDER OR SUPPLIES AY NURSING & RE	HABILITATION FACILITY	٥	IEET ADDRESS, CITY, STATE, ZIP COD OB WYOMING ROAD #38 WINGSVILLE, KY 40360		· · · · · · · · · · · · · · · · · · ·
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F 281 F 309 SS=E	one responsible to unaware that the timely manner. 483.25 PROVIDE HIGHEST WELL Each resident mu provide the nece or maintain the himental, and psycone.	August, 2010, but was now the or tracking labs. She was lab had not been obtained in a ECARE/SERVICES FOR BEING ust receive and the facility must ssary care and services to attain ighest practicable physical, hosocial well-being, in the comprehensive assessment	F 281	will flag the nurse that a lamissed. The notebook wichecked daily.  4. Weekly during the interdisciplinary care commedical records will audit of those residents schedul plans to ensure labs have obtained as ordered. A reforwarded to the Director weekly.	ference the charts ed for care been port will be	
	by: Based on Interview determined the function (19) sa Care Protocol with (Residents #12). The findings Included Review of the function of the	iENT is not met as evidenced aw and record review it was acility failed to provide the and services for four (4) of impled residents when the Bowel as not implemented consistently #18, #8, and #6).  ude:  cility's Bowel Care Protocol raing Assistant/Nursing would shift if a resident had a bowel policy stated if a resident had ays without having adequate in, the bowel protocol would be a Clinical Record revealed as admitted on 11/18/10 with in Included Diabetes, and status post Cerebrovascular		F309 It is and was on the survey the policy for Rid Nursing and Rehabilitatic each resident receives an facility must provide the care and services to attain maintain the highest pracephysical, mental, and psychological, in accordance comprehensive assessment of care.	geway on to ensure d the necessary n or cticable ychosocial e with the	02/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTAUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
•		185254	e. Wil	NG			5/ <b>2011</b>	
		ABILITATION FACILITY	ΙD	4	REET AODRESS, CITY, STATE, ZIP CODE 08 WYOMING ROAD #38 DWINGSVILLE, KY 40380 PROVIDER'S PLAN OF CORRECT	FION	(AK)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PAEF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X6) GOMPLETION DATE	
F 309	dated 11/19/10 revereceive Lactulose, a bowel movement in Bowel Information 1 December revealed bowel movement for December 1. Review Administration Reconstruction December revealed administered, as or period.  2. Review of the Cl Resident #18 was a diagnoses which in and Status Post Ce Review of the Physiand renewed month to receive Lactulose as needed for consinformation Tracking revealed Resident for the four (4) day and September 17 through September 18 total Review of Resident Review of Review	Review of the Physician Order paled the resident was to 20 Grams as needed for no three (3) days. Review of the Fracking Log for the month of 1 Resident #12 dld not have a per five (5) days beginning lew of the Medication ord (MAR) for the month of	F	309	1. Resident #12 has been disc to home. Resident #18 remains in the fand is being monitored closel his diagnosis of constipation diagnosis of volume depletion Resident #8 remains in the fact He has a terminal diagnosis with minimal P.O. intake. He is be monitored closely. Resident #6 remains in the fact She requires frequent narcotic related to a fracture. She is be monitored closely.  2. All nursing staff (licensed unlicensed) were inserviced to bowel care protocol on 01/27 the Administrator and Director Nursing. All resident bowel records with reviewed daily by the night slanurse to ensure the bowel profinglemented accurately. Dail of residents who require bowel intervention will be forwarded Director of Nursing. All resident bowel records has reviewed by the Director of Norsing. All resident bowel records has reviewed by the Director of Norsing.	acility y due to and on cility. vith eing and on the // I by or of II be oift tocol is ly a list el d to the ve been		

#### PRINTED: 02/09/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLEYED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A, BUILDING C B. WING 185254 01/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #36 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX LEACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 F 309 Continued From page 15 constipation related to the resident's decreased 3. Daily the night shift nurse will immobility and history of a Cardlovascular monitor the bowel log to ensure Accident (CVA). Interventions included to monitor residents are having adequate and record bowel movements, to report if the resident had not had a bowel movement in three elimination and follow up days, and to initiate bowel protocol if needed. intervention. The day shift charge nurse will initiate necessary 3. Clinical Record review revealed Resident #8 intervention. The bowel protocol was admitted on 04/03/08 with diagnoses which will be implemented if the resident included Chronic Pain and Depression. Review of the Physician's Order, dated 10/22/10 and has not had a bowel movement in (3) renewed monthly, revealed the resident was to three days. Day one a laxative will receive Lactulose, 20 grams as needed for no be administered, if no results day bowel movement in three (3) days. Review of the two a fleets enema will be Bowel Information Tracking Log for December 2010 revealed Resident #8 did not have a bowel administered, if no results day three movement for the four (4) day period between a soap suds enema will be December 22 and December 25. Review of the administered. The Director of MAR for December 2010 revealed no Lactulose Nursing will receive a list (Monday was given, as ordered, during that period. through Friday) and charge nurse Review of Resident #8's Comprehensive Plan of (Saturday/Sunday) of those residents Care, revised on 11/09/10, revealed the facility who require assistance with bowel had assessed the resident for the potential for elimination. constipation related to the resident's immobility. narcotic use, and chronic complaints of constipation. Interventions included to monitor 4. As a part of the facility's ongoing and record bowel movements and to report if the quality assurance program the resident had not had a bowel movement in three Director of Nursing or assessment days; to initiate bowel protocol if needed; and, nurse will audit 10% of all bowel Lactulose as needed.

4. Review of the Clinical Record revealed

Resident #6 was admitted on 04/28/10 with

Depression. Review of the Bowel Information Tracking Log for December 2010 revealed no documented evidence the resident had a bowel movement for the six (6) day period between

diagnoses which included Dementia, Anxiety, and

elimination records daily (Monday

through Friday) to ensure the above

process is being completed. This

process will be ongoing.

To: 18592462307

Page: 18/68

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUI	LDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		185254	B. Wil	IG			3/2011
	ROVIDER OR SUPPLIER	ABILITATION FACILITY		40	EET ADDRESS, CITY, STATE, ZIP CODE 16 WYOMING ROAD #38 WINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OFFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OFO BE	OOMPLETION DATE
F 309	December 21 and Physician's Order, monthly, revealed Lactulose, 20 Granneeded if no bowe Mar for December was given, as order interview with Cert #13 on 01/21/11 at were responsible fevery resident, every r	December 27. Review of the dated 09/22/10 and renewed Resident 36 was to receive ms every three (3) days as I movement. Review of the 2010 revealed no Lactulose ared, during the period.  ified Nursing Assistant (CNA) to 1:50 PM revealed the CNAs or filling out the bowel log, on ery shift. She stated the log	F;	809			
F 323 88=G	of Nursing on 01/2 protocol had been education had been monitoring was in been fully implement however, record rhad not been impliprotocol in Novem Residents #6, #8, 483.25(h) FREE CHAZARDS/SUPEI The facility must environment remains is possible; and	OF ACCIDENT RVISION/DEVICES Insure that the resident sins as free of accident hazards deach resident receives slon and assistance devices to	F	323	F323 It is and was on the d survey the policy of Ridgev Nursing and Rehabilitation that the resident's environm remains as free of accident as is possible; and each resi receives adequate supervisi	vay to ensure lent hazards dent	02/18/11

	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUI		G	COMPLE	TED
		185264	e, wir	VG		01/28	5/2011
	ROVIDER OR SUPPLIER	ABILITATION FACILITY		41	EET ADDRESS, CITY, STATE, ZIP CODE 05 WYOMING ROAD #38 WINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	ID PAGF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRINCENCY)	ULD BE	(X6) COMPLETION DATE
F 323	This REQUIREME by: Based on observa review it was deter identify environme falls related to side (19) sampled resid 06/17/10, Residen side rails raised. failed to identify siresident's fall, des resident's attempt rails raised. This if from re-assessing use of side rails. from the bed with and was hospitaliz fractured hip. The factors of the two risk factors assoc rails on 06/17/10 a #13 sustained a fr Hip Arthroplasty (I) The findings inclu Review of the "Fa reports would be a Nursing and a fall completed. Review of the "Six revealed side rail completed upon a	interview and record remined the facility failed to not risk and causal factors for realts for one (1) of nineteen dents (Resident #13). On the facility's fall investigation de rails as a causal factor to the pite staff knowledge of this to get out of bed with the side railure prevented the facility the resident for continued sale Resident #13 had a second fall side rails raised on 08/08/10, red for surgical repair of a facility failed to identify causal fails and failed to re-evaluate lated with climbing over side and on 08/08/10 when Resident actured right hip requiring Total hip replacement).	F	323	assistive devices to prevent accidents.  1. Resident #13 remains in the facility. Her condition has changed fair now bedfast and rarely resident assessment remunchanged.  2. All residents who have on side rail use have been review accuracy of their assessment possible reduction, by the Di Nursing and Administrator, review was conducted on 02.  3. Weekly during the interdisciplinary plan of care the Director of Nursing and/Coordinator will review the assessment for accuracy. If resident who uses bilateral si experiences a fall within 72 the incident the Director of Nursing and/I review the side rail asse to ensure accuracy of the asses All accident reports and investigations are reviewed of (Monday through Friday) by Administrator and/or Director Nursing to ensure a safe environment.	ders for wed for and rector of This /17/11  meeting or MDS side rails hours of Nursing sament dessment.	

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) OATE S COMPL	
		185254	B, WING _	<u> </u>	01/2	C 25/2011
	ROVIDER OR SUPPLIER AY NURSING & REP	IABILITATION FACILITY	4	REET ADDRESS, CITY, STATE, ZIP COL 106 WYOMING ROAD #38 DWINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(D PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 323	any significant chicould be consider as a restraint short side rall assessment quarterly MDS as:  Review of the "Recot/09/02, revealer reassessing the united an incident (for use of restraints, were to be re-eval determine their copolicy stated the formulate the united assessed the colliminate the united assessed Reside over the side ralls "Physician's Order revealed side rall for Resident #13" interview, on 01/2 nurse stated the formulate the united assessed Reside over the side ralls interview, on 01/2 nurse stated the formulate the 04/30/10 Side facility continued no possibility to continued no possibility to continued dated 05/06/10 the #13's side rails as	ange. Additionally, full side ralls ed a restraint and if assessed ald be treated accordingly. The ents were completed with the sessments.  Instraint-Physical® policy, dated do no information related to se of a restraint after a resident all) which may be related to the Per the facility's policy, restraints fluated at least quarterly to portinued need. Additionally, the acility should make every effort se of the restraint.  It to the facility on 02/16/04 with included Dementia and lead 03/15/10, revealed the facility on the facility on the facility of the oditional of the facility of	F 323	for the residents. A compwas conducted by the Adand Director of Maintens 02/17/11 to identify any hazards.  4. As part of the facility quality assurance program Director of Nursing will of all restraint assessment to ensure accuracy. This continue for six months, the Director of Maintena conduct an audit for safe This will be ongoing.	ministrator ance on safety s ongoing the audit 10% audit will Monthly ance will	
	Heview of the "C	omprehensive Care Plan" dated			enetic internal	1

PRINTED: 02/09/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B, WING 185254 01/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LEC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** F 323 Continued From page 19 F 323 05/12/10 revealed Resident #13's side ralls were identified as a restraint. The facility's goal related to use of the side rails was for the resident to be free from injury. Additional review of the care plan for the problem "Routine Care Needs" revealed the side rails were to be up times two (2) with interventions which included: dated 05/14/08, the right side rail to be up, dated 05/12/10 seatbelt alarm. Review of the "Nurse's Notes" and a "Resident Accident/Incident Report" dated 06/17/10 revealed Resident #13 was found sitting on the floor beside the bed with two (2) long side rails in use. The facility assessed resident #13 as having no injuries. Per the incident report, the resident was getting in or out of bed. However, review of the incident report revealed no documented evidence that the facility identified the side ralls as a casual factor in the resident's fall. Interview, on 01/24/11 at 7:19 PM, with Registered Nurse (RN) #2 revealed she was on duty 06/17/10 when Resident #13 was found on the floor. The RN stated the resident had to have "squirmed" through the side rails in order to get out of bed. Interview, on 01/24/11 at 4:51 PM, with State Registered Nurse Aide (SRNA) #13 revealed he was on duly 06/17/10 when Resident #13 was found on the floor. Per the SRNA the side rails were up. The SRNA stated Resident #13 would slide to the foot of the bed and try to get out. He stated the nurses were aware of the resident's

habit of sliding to the foot of the bed.

In interview, on 01/24/11 at 5:49 PM, SRNA #7 was on duty when Resident #13 fell on 06/17/10.

PRINTED: 02/09/2011

		HAND HUMAN SERVICES		,		D: 02/09/2011 MAPPROVED
		E & MEDICAID SERVICES				). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION	(X3) DATE (	BURVEY ETEO
		185254	B. WING		01/3	C 25/2011
	ROVIDER OR SUPPLIER  AY NURSING & REH	ABILITATION FACILITY	s	TREET ADDRESS, CITY, STATE, ZIP COD 406 WYOMING ROAD #36 OWINGSVILLE, KY 40360	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
F 323	entered the room to SRNA verified the of the bed and attenurses were award to get out of bed.  Interview, on 01/24 revealed Resident bed prior to the fall climb out of the bed interview, on 01/25 RN#3/MDS nurse incident report and see anything about did not complete a 06/17/10 fall. RN # the 06/17/10 fall. RN # the 06/17/10 fall for Resident #13 and other interventions which included confrequently, remind transfer without as: pad alarm to the bed confirmed that she as a causal factor that complete a readetermine if contine for this resident.  Review of the "Conrevealed the facility trauma, potential for Psychotropic drug incontinence, and fineluded the following incontinence.	e side rails were up when she o assist with the resident. The resident would slide to the foot ampt to get up. She stated the other of the resident's attempts with a tried to climb out of the on 06/17/10 and "still tries to d".  1/11 at 3:50 PM, with SRNA #5 #13 tried to climb out of the on 06/17/10 and "still tries to d".  1/11 at 3:50 PM, with revealed, after reviewing the line Nurse's Note, she did not the side rails; therefore, she "Side Rail Assessment" for the resident assessment on could see no reason to add any than those she had suggested allow-up assessment on could see no reason to add any than those she had suggested allow visual checks of resident resident not to stand or esistance, and add a pressure and RN #3/MDS nurse had not identified the side rails to the fells and therefore did seessment of Resident#13 to use of side rails was safe in the prehensive Care Plan" ridentified problems related to or injury related to falls, use, bowel and bladder alts on 06/17/10 which ng interventions: dated	F 32			
<u>.</u>	05/14/08 included t	he right side rail to be up; stbelt alarm; dated 06/17/10				

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		AND HUMAN SERVICES  & MEDICAID SERVICES					APPROVEC   0938-0391
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE LDING	CONSTRUCTION	COMPLETED	
		185254 .	B, Wif	1G		91/2	5/2011
AME OF P	ROVIDER OR SUPPLIER				Y ADDRESS, CITY, STATE, ZIP COU WYOMING ROAD #38	E	
IIDGEW/	ay nursing & Reh	ABILITATION FACILITY			INGSVILLE, KY 40360		
(X4) ID PREFIX TAG	(EACH DESICIENC)	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF YAC		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	SKOULD SE	(X6) COMPLETION DATE
F 323	Continued From pa	ige 21	F	323			
	continue visual che	cks of resident frequently and to stand or transfer without pressure pad alarm to the bed.					
	Practical Nurse (LF "Side Rall Assessn review of the Incide the Nurse's Notes need to complete of the side rails to continued use.	i/11 at 2:53 PM, with Licensed PN) #1, who also completed nents", revealed based on her ent report, dated 06/17/10, and for the 06/17/10 fall, she would a more comprehensive review determine the need for their					
	president of Clinic on the incident rep the 06/17/10 fall, s	5/11 et 3:55 PM, with the Vice at Operations revealed based for and the Nurse's Note for the would assume the resident I the bed but would need tion.					
	9:30 AM, revealed #13 lying on the flace having no injur 4:41 PM, with RN 08/08/10. The RN	rse's Notes", date 08/08/10 at I the facility staff found Resident for and assessed the resident ies. Interview, on 01/24/11 at #1 revealed she was on duty on I stated when she entered the resident was lying on the sted the resident would have had					
	to have climbed of the bed. The First time she had fallen getting 01/25/11 at 10:43 Nurse Aide (SRN was sitting on the room on 08/08/10 rails were up. as	wer the side rails or out the foot in stated the 08/08/10 fall was was aware that Resident #13 out of bed. Interview, on AM, with State Registered A) #6 revealed Resident #13 floor when she entered the D. The SRNA stated the side they always were when the ed. The facility was unable to					

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PRINTED: 02/09/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO<u>. 0938-0391</u> (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING \_ 01/25/2011 185254 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 406 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES CXAN ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 22 F 323 report or investigation related to this fall. Further review of the Nurse's Note", dated 08/08/10 at 1:30 PM, revealed Resident #13 had pain in the right lower extremity upon transfer to bed and was sent to the hospital for further evaluation. Review of the hospital "Progress Note", dated 08/11/10, revealed Resident #13 had undergone a Total Hip Arthroplesty (hip replacement) after a fracture to the right hip. Review of the "Side Rail Assessment" form revealed the facility continued to assess Resident #13 as having no possibility that he/she climbed over the side rails on 08/20/10. Interview, on 01/25/11 at 3:50 PM, with RN#3/MDS nurse revealed when conducting a review of the side rails she would interview staff, review clinical records, and look at any incident reports that may have been completed. Interviews, on 01/24/11 at 4:51 PM, 5:28 PM, and 5:49 PM, with SRNAs #5. #9, and #7 revealed they were aware that Resident #13 would scoot to the foot of the bed and attempt to get out of bed, by sliding down to the foot of the bed. They stated the Nurses were aware Resident #13 would attempt to get out of bed. While interviews with facility staff identified they were aware of the resident's tendency to attempt to get out of bed while the side rails were raised, additional review of the "Side Rall Assessment" form revealed no evidence the facility re-evaluated Resident #13's side rails as a causal factor for the falls on 06/17/10 or on 08/08/10.

Observation of Resident #13, on 01/21/11 at 11:00 AM, revealed the resident was lying on the bed with side rails in place. Observation, on 01/21/11 at 12:40 PM, revealed the resident was

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

F 323 Continued From page lying on the bed with the place. Two (2) side railed in the right side rail on the left side of the rail on the right side rail on the bed with four (483.35(d)(1)-(2) NUT PALATABLE/PREFER					01/20	/2011
F 323 Continued From page lying on the bed with the place. Two (2) side railed in the right side rail on the left side of the rail on the right side rail on the bed with four (483.35(d)(1)-(2) NUT PALATABLE/PREFER	ILITATION FACILITY		400	ET ADDRESS, CITY, STATE, ZIP CODE 8 WYOMING ROAD #38 NINGSVILLE, KY 40360		
lying on the bed with the place. Two (2) side range of the left side of the left side of the left side of the left side range of the bed with the place. Two (2) side range of the left	MENT OF DEFICIENCIES JUST BE PRECEDED BY FULL JUENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO 8E	COMPLETION DATE
food prepared by met	three (3) half side rails in alls on the right and one (1) de. Observations, on revealed the resident was three (3) half side rails in alls on the left and one (1) side. Observation, on revealed the resident lying (4) half side rails in place, s, on 01/25/11 from 11:50 wealed the resident was lying (4) half side rails in place. RITIVE VALUE/APPEAR, P TEMP		364	F364 It is and was on the day survey the policy of Ridgewa Nursing and Rehabilitation to provide food prepared by me that conserve nutritive value, and appearance; and food that palatable, attractive, and at the proper temperature.	thod flavor,	02/18/11
by: Based on observation determined the facilit served at proper tem foods served at subs The findings include: Observation of food 12:40 PM revealed to degrees Farenheit to	temperatures on 01/19/11 at emperatures of ninety (90) or broccoll, ninety-two (92) or stuffing with gravy.			<ol> <li>The residents were no advantage affected by the food temperature.</li> <li>All dietary staff were inseen 02/04/11 by the Administ proper food temperatures.</li> <li>A plate warmer was purel 0 on 01/14/11 to help maintain food temperatures. In additional and the contraction of the contraction of</li></ol>	rviced rator on hased in proper	
eighty-eight (88) deg	grees Farenheit for pork ems served to residents			daily temperature logs will forwarded to the Administrative review.	tor for	

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 02/09/2011 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE	<u>0. 0938-0391</u> SURVEY LETED
<del></del>		185254	8, WIN		01/	C (25/2011
		BILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIF 408 WYOMING ROAD #38 OWINGSVILLE, KY 40360		<u>25/2011</u>
(X4) ID PREFIX TAG	{EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 364 F 371 SS≖E	Dietary Manager reviservice temperature hundred and fifteen greater for hot food (41) degrees for cold (41) degrees temperature at Point dated, revealed vegibelween 115-125 debe at least between and casserole disher gravy) should be at 1 degrees Farenheit. 483.35(I) FOOD PROSTORE/PREPARE/S	1 at 12:30 PM with the realed her goals for point of s for the residents were one (115) degrees Farenheit or items and less than forty-one d food items.  It policy regarding point of stilled "Minimum t of Service to Resident," not etables should be at least grees Farenheit, meat should 115-125 degrees Farenheit is (such as the stuffing with east between 115-120	F 37	4. As part of the facil quality assurance prog Dietary Manager will weekly at varying time proper temperatures of report will be reviewed the QA committee of the findings. This process for 6 months.	ity's ongoing gram the audit trays es to ensure food. A dimonthly by he above will continue the day of Ridgeway ation to store, discrete good	02/18/11
	(2) Store, prepare, di under sanitary condit under sanitary condit This REQUIREMENT by: Based on observation determined the facilit distribute and serve fonditions as evident	r is not met as evidenced n and interview it was y failed to store, prepare,		1. The out of date food drinks were immediate from the refrigerator. Sare now turned in one of Handles outward to precontaining scoops when them. Food temperatur been re-implemented, monitored daily by the Manager.	ly removed Scoop handles lirection. Event In reaching for It logs have This is being	(

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PAINTED: 02/09/2011

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 185254 01/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PAÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 F 371 Continued From page 25 multiple directions, staff soft drink stored in 2. All dietary staff were inserviced freezer and lack of temperature measuring on on 02/04/11 by the Administrator on food items served to residents. the above issues. The findings include: 3. The Dietary Manager will daily Observation on 01/18/11 at 2:50 PM revealed two (Monday through Friday) and the (2) twenty-eight (28) ounce containers of sour cook (Saturday and Sunday) will cream with manufacturer's expiration dates of check food storage, utensil storage, 01/02/11 for one container and 01/16/11 for the and food temperature log for other. compliance. Interview with the Dietary Manager on 01/19/11 at 3:10 PM revealed the sour cream should have 4. As part of the facility's ongoing been used or discarded before or on the quality assurance program dietary expiration date. sanitation will be monitored monthly Observation on 01/18/11 at 3:00 PM revealed a for the next six months by the drawer in the island food preparation table Dietary Manager. Daily the Dietary containing scoops with the handles turned in Manager is auditing key areas for multiple directions. sanitation and reporting to the Interview with the Dietary Manager on 01/18/11 at Administrator. Monthly the dietician 3:00 PM revealed the scoops should be stored will review sanitation and report to upside down and handles turned in one (1) the Administrator. Included in this direction to prevent sediment and hands from report is equipment sanitation. coming in contact with the food contact surface. storage of utensils and food, etc. Observation on 01/19/11 et 11:45 AM revealed These assessments will be made part Dietary Aide #8 was measuring temperature of of the OA minutes. food items to be served to residents on the lunch trayline. It was noted there were no temperatures taken on the pureed vegetables, the pureed stuffing, to determine if adequate temperatures were reached during the cooking and holding process. Coffee and these items were subsequently served to residents eating dinner at the facility.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105254	B. WING		C 01/25/2 <u>011</u>
	ROVIDER OR SUPPLIER AY NURSING & REH	ABILITATION FACILITY	S	TREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES.)	ULD BE COMPLETION
F 371	12:15 PM revealed temperatures of all drinks are served to explain this instance 483.70(h) SAFE/FUNCTION/E ENVIRON  The facility must present and comformal and comformal served determined the fact functional, senitary for residents, staff cracked tiles on A lin shower room on metal hand rall in shandrall in the shown appearance of a heavy plastic tin shower room on hallway going between the nurse's station warped tiles.  Observations of heavy plastic tin shower room on hallway going between the nurse's station warped tiles.	ary Aide #8 on 01/19/11 at she normally does take the food items before food and presidents. She could not e.  AL/SANITARY/COMFORTABL  ovide a safe, functional, ortable environment for a safe, functional, ortable environment for a safe, functional, ortable environment for and interview, it was illity failed to provide a safe, and comfortable environment and the public as evidenced by Hall, the tille behind the bathtub C Hall was cracked, broken thower room C and broken wer room.	F 46		nitary, t for c. several tes in e been ly to re- crete is floor ensive been on pected . astic d. It bath has and the d for the orarily cted the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A &U		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		186264	B. Wil	NG			C <b>5/2011</b>
	ROVIDER OR SUPPLIER  AY NURSING & REH	ABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD #38 OWINGSVILLE, KY 40360				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLO BE	(K6) COMPLETION DATE
F 465 F 520 SS=E	Interview on 01/19 from room A11 rev complaining about months. The resid good with previous addressed with this interview revealed been in to attempt do so.  Interview on 01/19 Maintenance Direct attempted to resolvin a plumber. Whe damaged tile, the finas procured seve for corporate to give stated he was afra hurt on either the onear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the conear the nurse's stated he was afra hurt on either the cone was afr	/11 at 3:45 PM with the resident ealed he/she had been the water temperature for lent stated, "It didn't do much administration, but it was sone, pretty quickly". Further the maintenance man had to fix it, but he was unable to //11 at 3:55 PM with the stor, revealed he had we the situation, but had to call en interviewed related to the Maintenance Director stated he ral estimates and was waiting re approval. The Director id someone was going to get cracked or badly warped tiles ation.		520	<ol> <li>All maintenance requests being monitored by the Administrator (Monday thro Friday). On Saturday and State charge nurse will call the Maintenance Director for emrepairs.</li> <li>A maintenance request was completed for any necessary Once the repair is completed be forwarded to the Administ with a date repaired and initial who repaired the problem.</li> <li>As part of the facility's on quality assurance program maintenance will provide the Administrator with a report of any repairs which have not be completed and the estimated completion. In addition, mor maintenance supervisor will an audit identifying any safet hazards of necessary repair.</li> </ol>	ugh unday  ill be repairs. it will trator als of going onthly etailing een time of othly the conduct y	
	committee meets a issues with respec and assurance act develops and impl	ment and assurance at least quarterly to identify to which quality assessment ivities are necessary; and ements appropriate plans of entified quality deficiencies.			F523 It is and was on the day survey the policy of Ridgewa Nursing and Rehabilitation to maintain an effective quality assessment and assurance con	<b>y</b>	02/19/11

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 02/09/2011 FORM APPROVED OMB NO. 0938-0391

		A. BUILDIN	L3		
	185254	B. WING _		C 01/25/2011	
NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATIO	N FACILITY	4	REET ADDRESS, CITY, STATE, ZIP CODE 06 WYOMING ROAD #36 DWINGSVILLE, KY 40360		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF SUMMARY STATEMENT OF FREGULATORY OR LSC IDENTIFY	RECEDEO BY FULL	PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLI	ETION
A State or the Secretary may disclosure of the records of a except insofar as such disclosompliance of such committee requirements of this section.  Good faith attempts by the condition of the section of this section.  Good faith attempts by the condition of the section of the section of the section of the section.  This REQUIREMENT is not by:  Based on observation, intervireview it was determined the develop and implement an apaction to correct identified quant of the facility was cited, in 2010 uneven floor tiles throughout the current survey, the tiles have replaced as indicated on the The findings include:  Observations during the survand uneven tiles were present building, with the worst being station. Review of the deficit Standard Survey revealed the same damaged tiles. Recorrection revealed the facility compliance date of 06/28/20 replacement of the tiles.  Interview with the Maintenant 01/19/11 at 3:55 PM revealed corporate approvel to repair	uch committee sure is related to the se with the  mmittee to identify se will not be used as  met as evidenced few and record facility failed to ppropriate plan of ality deficiencies. 0, for cracked and the building. During sad not been Plan of Correction.  rey revealed cracked in throughout the p near the nurses ancies from the 2010 e facility was cited for eview of the Plan of ity alleged a 10 regarding  ice Director on d he was waiting on	F 520	1. The facility has obtained bids to replace the cracked to the hallway. These tiles have replaced numerous times on crack due to the unlevel consunder the tile. To correct the permanently will require extrenovation. A contract has a signed with Carroll Flooring 02/18/11 which details an excompletion date of 04/29/11. The metal handle bar and pleased bar have been remove should be noted one central been completely renovated a bath on B/C hall is schedule repairs. The cracked tile in shower room has been temperature problems 01/18/2011.  2. All department managers been inserviced on the facilic quality assurance program.  3. The Administrator will consult the contract of the plumber corresponds to the facilic quality assurance program.  Indicators have been developed for monthly meetings. Indicators have been developed for all departments.	les in e been ly to re- crete is floor ensive been on spected  astic d. It bath has end the d for the orarily ected the ity's  hair the A ule has een	

Facility ID: 100427

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A, 8U		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	·	185254	B. WI			1	C 5/2011
	ROVIDER OR SUPPLIE AY NURSING & RE	HABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #36 OWINGSVILLE, KY 40360				
(X4) ID PREFIX TAQ	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ULO BE	(X6) COMPLETION DATE
F 520	Services on 01/2 tiles could not sin beneath them wa aware the project She further state corporate level be	page 29 Vice President of Clinical 1/10 at 9:10 PM revealed the hply be replaced as the floor is uneven. She stated she was would be an extensive one. If blds had been taken at the out a specific plan for the out yet been determined.	F	520	4. The Administrator will en Quality Assurance activities conducted in a manner that a issues are brought forth and addressed timely. A quality assurance log has been made available to all staff so issue are not addressed on the cale indicators can be addressed or	are ssures s which ndar of	
•							

PRINTED: 02/07/2011

**DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 B. WING 185254 01/18/2011 NAME OF PROVIDER OR SUPPLIER STAGET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40300 PROVIDER'S PLAN OF CORRECTION **SUMMARY STATEMENT OF DEFICIENCIES** (X&) COMPLÉTION (X4) ID EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PAEFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 I INITIAL COMMENTS K 000 A Life Safety Code survey was initiated and concluded on 01/18/2011. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F". NFPA 101 LIFE SAFETY CODE STANDARD K 018 K 018 K018 It is and was on the day of 02/28/11 39=D survey the policy of Ridgeway Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or Nursing and Rehabilitation to assure hazardous areas are substantial doors, such as doors close properly to resist smoke. those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 1. The door to rooms A6 and C3 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is have been adjusted to close properly. no impediment to the closing of the doors. Doors are provided with a means suitable for keeping 2. All doors have been assessed to the door closed. Dutch doors meeting 19.3.6.3.6 ensure proper closure. are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations 3. Monthly as part of the in all health care facilities. maintenance rounds all doors will be checked to ensure proper closure. 4. As part of the facility's Quality Assurance program the Maintenance Director will check doors monthly to ensure proper door closure. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain corridor doors, according to NFPA standards. The deficiency affected four (4) residents, and the potential to affect staff and visitors.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director

(XE)DATE 3/17/1/

Anaddiciency statement ending with an asterisk (\*) denotes a deliciency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days in the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		AND HUMAN SERVICES				APPROVED 0938-0391		
	OF DEFICIENCIES	& MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	URVEY		
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPA	; IEU		
		185254	B. WING		01/1	8/2011		
	ROVIDER OR SUPPLIER	ABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360					
(X4) (D PREFIX TAG	SUMMARY 8T/	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOUL <b>O BE</b>	(X6) COMPLETION DATE		
K 018	Continued From pa	age 1	K 018		***			
	The lindings includ	<b>e</b> :			•			
	resident room A6, corner of the door. confirmed with the Interview on 01/18 Maintenance Direct	/18/2011 at 3:56 PM, revealed had a gap at the top right. The observation was Maintenance Director. /2011 at 3:56 PM, with the stor, revealed he had not as having a gap, before the urvey.			·			
	a trash can was pl C3 door. The obse Maintenance Direct Interview on 01/18 Maintenance Direct	/18/2011 at 4:00 PM, revealed aced in front of resident room ervation was confirmed with the ctor.  1/2011 at 4:00 PM, with the ctor, revealed the trash can een placed in front of the door						
	Reterence: NFPA	101 (2000 edition)				\ \		
	other than require openings, exits, of substantial doors 1-3/4 in. (4.4-cm) or of construction 20 minutes and substantial passage of smok Exception No. 2: protected through automatic sprinkl 19.3.5.2, the door 19.3.6.3.1 shall not suited the substantial passage of smoken the substantial passage of substantial passage of smoken the substantial passage of s	protecting corridor openings in denciosures of vertical r hazardous areas shall be such as those constructed of thick, solid-bonded core wood that resists fire for not less than hall be constructed to resist the e.  In smoke compartments fout by an approved, supervised er system in accordance with r construction requirements of ot be mandatory, but the doors ted to resist the passage of						
K 021	smoke. 5 NFPA 101 LIFE \$	SAFETY CODE STANDARD	K 025	5				

PRINTED: 02/07/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A BUILDING B. WING 185254

NAME OF PROVIDER OR SUPPLIER

01/18/2011 STREET ADDRESS, CITY, STATE, ZIP CODE **8EN GAOR DRIMOYW 804** RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X6) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PAEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRĖFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY K 025 K 025 Continued From page 2 K025 It is and was on the day of 02/28/11 Smoke barriers are constructed to provide at survey the policy of Ridgeway least a one half hour fire resistance rating in Nursing and Rehabilitation to ensure accordance with 8.3. Smoke barriers may smoke barriers are maintained terminate at an atrium wall. Windows are according to NFPA standards. protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two 1. The hole between A and B separate compartments are provided on each floor. Dampers are not required in duct corridor in the smoke barrier has penetrations of smoke barriers in fully ducted been repaired. The smoke barrier for heating, ventilating, and air conditioning systems. B and C corridor has been repaired. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 2. All smoke barriers have been checked for proper maintenance. This STANDARD is not met as evidenced by: 3. Anytime someone accesses the Based on observation and interview, it was attic area maintenance will check to determined the facility falled to ensure smoke ensure that no smoke barriers have barriers were maintained, according to NFPA standards. The deficiency has the potential to been affected. affect sixty (60) residents, staff and visitors. 4. As part of the facility's ongoing The findings include: Quality Assurance program the Maintenance Director will check all Observation on 01/18/2011 at 2:47 PM, revealed an eight (8) Inch square hole in the smoke barrier smoke barriers at least quarterly. between the A and B corridor. The observation was confirmed with the Maintenance Director. Interview on 01/18/2011 at 2:47 PM, with the Maintenance Director, revealed he had not had the opportunity to check the smoke barriers, since he took over the position of Maintenance Director in November of last year. Observation on 01/18/2011 at 2:58 PM, revealed a two (2) x tour (4) hale in the smoke barrier for

the B/C corridor. The facility had failed to follow the Plan of Correction for the last survey. The facility was cited in 2010 during the last survey for the same penetration in the smoke barrier of B/C.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	` `		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		Control of the Contro	A. au	LDING	01			
	185254			//G		01/	18/2011	
NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE	
K 025	facility would repartier. Interview on 01/16 Maintenance Dire the opportunity to he took over the p in November of la Interview on 01/16 Administrator, rev as to why the Plan to flix the penetrat B/C corridor.  Reference: NFPA 8.3.2° Continuity. Code shall be continuous fro wall, from a floor to a floor, or smoke barrier or a combination the continuous through all conce found above a ce including interstiti Exception: A smo occupied space is interstitial space; through the inters space, provided to the interstitial space; through the botto the interstitial spassage of smoke	ortion for last year stated the ir the penetration to the smoke ir the penetration to the smoke ir the penetration to the smoke placed at 2:58 PM, with the ctor, revealed he had not had check the smoke barriers, since position of Maintenance Director st year.  2/2011 at 5:30 PM, with the pealed she had no explanation of Correction was not followed ion in the smoke barrier for the construction an outside wall to an outside from a smoke barrier to a perior. Such barriers shall be alled spaces, such as those alling, all spaces. The shall not be required for an open an another the construction assembly of ace provides resistance to the see equal	K	025				
K 050 99=F	NFPA 101 LIFE S	by the smoke barrier. BAFETY CODE STANDARD	К	050				
	varying condition	d at unexpected times under s, at least quarterly on each shift.					post Prop. 4 of 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185254		IDENTIFICATION NUMBER:	A. BU	LDING	G 01	(X3) DATE SURVEY COMPLETED				
		B. WING			01/1	B/2011				
NAME OF PROVIDER OR SUPPLIER  RIDGEWAY NURSING & REHABILITATION FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360						
(X4) ID PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency must be preceded by Full Regulatory or Lac Identifying Information)			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X6) COMPLETION OATE			
K 050	Continued From page 4 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7,1.2			050	K050 It is and was on the d survey the policy of Ridgew Nursing and Rehabilitation to conduct fire drills according NFPA Standards.  1. A fire drill schedule has developed and implemented	way i to ig to is been				
	This STANDARD is not met as evidenced by: Based on Interview and record review it was determined the facility failed to conduct fire drills, according to NFPA standards.  The findings include: Record review on 01/18/2011 at 5:00 PM, of the Fire Drills for the facility, revealed the 2nd and 3rd quarter drills for 2010 were missing. The observation was confirmed with the Maintenance Director.  Interview on 01/18/2011 at 5:00 PM, with the Maintenance Director, revealed he was unable to tocate copies of the lire drills conducted during the 2nd and 3rd quarter of 2010.  Reference: NFPA 101 (2000 edition) 19.7.1.2° Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals				<ol> <li>All staff were inserviced 02/04/11 of fire drill proced the Administrator and Direct Nursing.</li> <li>Monthly the Maintenanc Director will ensure at least drill is conducted and recommon rotating shifts) of the drills, will be sent to the Administ 4. As part of the facility's of Quality Assurance program drills will be reviewed and a maintained by the Administ</li> </ol>	e one fire ded (on Copies rator.				

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	EMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING 01  B. WING			(X3) DATE BURVEY COMPLETED 01/18/2011		
NAME OF PROVIDER OR SUPPLIER			<u> </u>				1/2011	
RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD #38 OWINGSVILLE, KY 40380					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE	
	conditions. When drills are con (2100 hours) and 6:00 a.m. (060 announcement sha permitted to be use Exception: Infirm of the building.	ion required under varied iducted between 9:00 p.m. 0 hours), a coded		062	K062 It is and was on the	e day of	02/00/11	
\$\$=D	Required automatic continuously maint condition and are in periodically. 19.7 9.7.5	e sprinkler systems are alned in reliable operating aspected and tested 2.6, 4.6.12, NFPA 13, NFPA 25,			survey the policy of Ridg Nursing and Rehabilitation sprinklers are maintained to NFPA standards.  1. The blown-in insulation	eway on to ensure according on was	02/09/11	
	Based on observat determined the fac were maintained, a The deficiency has (30) residents, staf The findings include	e:			2. All sprinkler heads ha assessed and are in prope condition.	r working		
	three (3) sprinkler were covered with observation was control interview on 01/18. Maintenance Director the insulation of Reference: NFPA	/18/2011 at 3:00 PM, revealed heads located in the attic area blown in insulation. The onfirmed with the Maintenance //2011 at 3:00 PM, with the stor, revealed he was unaware a the three (3) sprinkler heads.			<ul> <li>3. Monthly as part of manaudit all sprinkler heads to observed.</li> <li>4. As part of the Quality program the above audits reviewed by the Administensure compliance.</li> </ul>	Assurance will be		

Facility ID: 100427

STATEMENT OF DEFICIENCIES ANN-CLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING 01			(X3) DATE SURVEY COMPLETED			
185254		B, WII	/G _	<del></del>	01/18/2011				
NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360					
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACT			ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE			
K 072 SS⊨F	Continued From paltoor level annually. Sprinklers foreign materials, paint, and physical in the proper orientation (sidewall). Any sprinkler shall be recorroded, damaged loaded, or in the im Exception No. 1:* Sconcealed spaces: above suspended of inspection. Exception No. 2: Si are inaccessible for salety considers operations shall be during each scheduning each s	Continued From page 6 floor level innually. Sprinklers shall be free of corrosion, oreign materials, eaint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or idewall). Any prinkler shall be replaced that is painted, for orded, damaged, paded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible or salety considerations due to process operations shall be inspected furing each scheduled shutdown.  MEPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No urnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.  7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, it was		K 072  K 072  K 072  K 1 is and was on the day survey the policy of Ridgew Nursing and Rehabilitation to maintain a means of egress.  1. The linen carts, medication and lift were moved.  2. All items that are in the hare moved at least every 30 moves when not in use.		lay of vay to on carts,	02/16/11		
	obstructions according to NFPA standards. The deficiency has the potential to affect sixty (60) residents, staff, and visitors.				egress. Items that are not be will be removed from the megress.	eing used			

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PRINTED: 02/07/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 B. WING 185254 01/18/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY, 40360 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID in (X5) (EACH CORRECTIVE ACTION SHOULD BE PAEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 072 Continued From page 7 K 072 4. As part of the facility's ongoing The findings include: Quality Assurance program monthly Observation during the Life Safety Code Survey a safety survey will be completed on 01/18/2011 between 2:20 PM and 3:30 PM. which addresses means of egress. revealed one (1) medicine cart, one (1) patient lift, one (1) clean ilnen cart and one (1) patient This will be completed by the records cart located in the A Wing Corridor. Maintenance Director. Further observation revealed one (1) clean linen cart parked in the B and C Corridor. The observation was confirmed with the Director of Maintenance. Interview on 01/18/2011 at 3:30 PM with facility staff, revealed the clean linen carts stay in the corridors at all times. Reference: NFPA 101 (2000 edition) 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. K144 It is and was on the day of NFPA 101 LIFE SAFETY CODE STANDARD K 144 02/16/11 K 144 survey the policy of Ridgeway S8≃F Generators are inspected weekly and exercised Nursing and Rehabilitation to inspect under load for 30 minutes per month in generators weekly and exercise accordance with NFPA 99. under load for 30 minutes per month. There was a change in Administration and Maintenance in November 2010. Several records were not able to be located after that date.

This STANDARD is not met as evidenced by:

emergency generator was maintained according to NFPA standards. This deficiency has the

Based on interview and record review, it was determined the facility failed to ensure the

and manually.

1. Generator logs are currently being

maintained in an electronic format

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> (X3) DATE SURVEY ((2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 B, WING 185254 01/18/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION (XE) SUMMARY STATEMENT OF DEFICIENCIES (O (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY K 144 K 144 Continued From page 8 2. All generator checks and run logs potential to affect sixty (60) residents, staff and will be checked monthly by the visitors. Administrator The findings include: 3. All generator checks and run logs Review of the emergency generator maintenance will be checked monthly by the logs on 01/18/2011 at 5:06 PM, revealed the Administrator. maintenance logs from 05/10/10 through 12/28/10 were missing. The observation was confirmed with the Maintenance Director. 4. Monthly as part of the Quality Assurance the generator checks and Interview on 01/18/2011 at 5:06 PM, with the logs will be reviewed by the Maintenance Director, revealed he could not find Committee. the missing logs for the emergency generator. Reference: NFPA 99 (1999 edition) 3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. 03/04/11 K 147 NFPA 101 LIFE SAFETY CODE STANDARD K147 It is and was on the day of K 147 SS=E survey the policy of Ridgeway Electrical wiring and equipment is in accordance Nursing and Rehabilitation to ensure with NFPA 70. National Electrical Code. 9.1.2 electrical wiring and equipment is in accordance with NFPA 70. 1. Extension cords have been removed from rooms where they This STANDARD is not met as evidenced by: were in permanent use. New outlets Based on observation and Interview, it was have been installed. The electrical determined the facility failed to ensure electrical wiring was according to NFPA standards. The panel has been labeled properly. deficiency affected ten (10) residents, staff and visitors.

The findings include:

2. All extension cords have been

removed at this time.

PRINTED: 02/07/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 105254 01/18/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 3. Monthly as part of the Quality K 147 K 147 Continued From page 9 Assurance audit the Maintenance Observation on 01/18/2011 at 3:46 PM, revealed Director will audit all rooms for an extension cord being used to power a television in resident room A7. Further extension cord usage. The electrical observation revealed the cord was affixed to the panel box will be audited annually. underside of the sink with nails and several fastening devices. During the Life Safety Code 4. The above mentioned audit will Survey, several more electrical cords were found in this manner. The rooms include but were not be reviewed monthly by the Quality Ilmited to A3, A5, A8, and C8. The observation Assurance committee. was confirmed with the Maintenance Director. Interview on 01/18/2011 at 3:46 PM, with the Maintenance Director, revealed that he would remove the electrical cords in use. Observation on 01/18/2011 at 4:18 PM, revealed an electrical panel located in the Mechanical Room was not labeled properly. Interview on 01/18/2011 at 4:18 PM, with the Maintenance Director, revealed the electrical panel was not labeled properly. NFPA 70 400-8, 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces NFPA 99, Chapter 3 Electrical Systems. 3-3,2,1.2 D

2. Minimum number of Receptacles. The number

of receptacles shall be determined by the

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**FORM APPROVED** 

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 B. WING 185254 01/18/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #88 RIDGEWAY NURSING & REHABILITATION FACILITY OWINGSVILLE, KY 40360 PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PREFIX (X6) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 147 Continued From page 10 K 147 intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.